DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 4729 (Rev. 05/01)

STATE OF WISCONSIN
ss. 255.075, Wis. Stats.

WISCONSIN WELL WOMAN PROGRAM (WWWP)
Cervical Cancer Diagnostic and Follow Up Report (DRF)

Information and Instruction on reverse side

PERSONAL INFORMATION

1. Last Name	2. First Name	3. Middle Initial
4. Maiden Name	5. Date of birth (mm/dd/yyyy)	

6. Social Security Number (Optional) or Client Identification Number

CERVICAL DIAGNOSTIC PROCEDURE - Check appropriate completed procedures

7. **Colposcopy and/or Endocervical Curettage** ☐ Yes ☐ No

☐ Client refused. ☐ Not done, give reason_____

Date performed (mm/dd/yyyy)

8. Provider / Clinic

9. With Biopsy

☐ Normal / Benign / Inflammation
☐ Other Non-malignant Abnormality (HPV, condyloma)
☐ CIN-I / Mild Dysplasia*
☐ CIN-II / Moderate Dysplasia*
☐ CIN-III / Severe Dysplasia / CIS*
☐ Invasive Squamous Cell Carcinoma*
☐ Adenocarcinoma*

*Complete status of final diagnosis

10. Without Biopsy

☐ Negative (WNL)
☐ Inflammation / Infection / HPV Changes
☐ Other abnormality
☐ Unsatisfactory

11. **Gynecologic Consultation** ☐ Yes ☐ No

☐ Client refused ☐ Not done, give reason_____

Date performed (mm/dd/yyyy)

12. Provider / Clinic

13. Results

Date of result (mm/dd/yyyy)_____

☐ Negative
☐ Inflammation / Infection / HPV Changes
☐ Other Abnormality
☐ Unsatisfactory

14. **Recommendation -** Must complete status of final diagnosis

Date performed (mm/dd/yyyy)_____

☐ Follow routine screening schedule_____months.
☐ Repeat Colposcopy ☐ Other Biopsy* ☐ LEEP* ☐ Cone*

☐ Short Term Follow up_____months_____procedure
☐ Pelvic Ultrasound ☐ Hysterectomy ☐ Other*

***Not paid by WWWP**

15. **Status of Final Diagnosis**

☐ Complete
☐ Client Deceased
☐ Lost to Follow up
☐ Pending
☐ Refused Work up

Date of Final diagnosis (mm/dd/yyyy)_____

16. **Final Diagnosis**

☐ Normal / benign / inflammation
☐ HPV / Condylomata / Atypia
☐ CIN I / Mild Dysplasia
☐ CIN II / Moderate Dysplasia*
☐ CIN III / Severe Dysplasia / CIS*
☐ Invasive cervical cancer**
☐ Adenocarcimoma*

*Complete treatment status section
**Complete Tumor Stage section

17. **Tumor Stage** - Reporting should be in TNM categories, not in summary categories.

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Unstaged ☐ Unknown

18. Treatment Status

☐ Treatment started on (mm/dd/yyyy)_____
☐ Refused by client
☐ Lost to follow up on (mm/dd/yyyy)_____
☐ Not indicated / not needed
☐ Client deceased. Date (mm/dd/yyyy)_____
☐ Other problems_____

19. Notes / Comments

Return completed top copy of form only to: WWWP, P.O. Box 6645, Madison, WI 53716-0645

White (Top) Copy - WWWP **Yellow (2nd) Copy - Provider** **Pink (3rd) Copy - Local Coordinating Agency**

INSTRUCTIONS FOR WISCONSIN WELL WOMAN PROGRAM (WWWP)
CERVICAL CANCER DIAGNOSTIC and FOLLOW UP REPORT FORM (DRF)

The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

PERSONAL INFORMATION

1. Print client's Last Name.
2. Print client's First Name.
3. Print client's Middle Initial.
4. Print client's Maiden Name, if applicable.
5. Indicate client's Date of Birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate client's Social Security Number (SSN) or Client Identification Number (CIN). The SSN is optional and will be used to determine the client's eligibility for services and to identify her status with other healthcare programs. The Local Coordinating Agency assigns the CIN.

CERVICAL DIAGNOSTIC PROCEDURE

COLPOSCOPY

7. Check whether a Colposcopy or Endocervical Curettage was performed. If the box Not Done is checked, then explain why. Indicate the Date the Diagnostic Colposcopy was performed. Use numbers for month, day and year, i.e. 01/15/2000.
8. Indicate the name of the Provider or Clinic where the Diagnostic Colposcopy was performed.
9. If a Colposcopy With Biopsy was performed, check the appropriate box to indicate the results.
10. If a Colposcopy Without Biopsy performed, check the appropriate box to indicate the results.

GYNECOLOGIC CONSULTATION

11. Check whether a Gynecologic consultation was performed. If the box Not Done is checked, then explain why. Indicate the Date the Gynecologic Consultation was performed. Use numbers for month, day and year, i.e. 01/15/2000.

12. Indicate the Name of the Provider or Clinic where the Gynecologic Consultation was performed.

13. Check the appropriate box to indicate the results

RECOMMENDATION

14. Indicate the Date that the Final Diagnosis was determined. Use numbers for month, day and year, i.e. 01/15/2000.

    Check the appropriate box to indicate the Recommendations. If Short Term Follow-up is recommended, please indicate the number of months from now. NOTE: It is required to complete the Status of Final Diagnosis.

STATUS OF FINAL DIAGNOSIS

15. Check the appropriate box to indicate the status of the Final Diagnosis.
    Indicate the Date the Final Diagnosis was made. Use numbers for month, day and year, i.e. 01/15/2000.
16. Check the appropriate box to indicate the Final Diagnosis.
17. Check the appropriate box to indicate the Stage of the Tumor, if 16 is marked invasive cervical cancer.
18. Check the appropriate box to indicate if Treatment Status and indicate the date. Use numbers for month, day and year, i.e. 01/15/2000.
19. This space can be used to make any Notes on the follow-up plan, treatment plan, clarifications, etc.

Return completed form, White(Top) Copy Only to:

WWWP
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Madison, WI 53716-0645